

FORM 108



The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 108
 600 Washington Street – 7th Floor, Boston, Massachusetts 02111
 Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
<http://www.mass.gov/dia>

DIA Board #
(If Known):

**INSURER'S COMPLAINT FOR MODIFICATION,
DISCONTINUANCE OR RECOUPMENT OF COMPENSATION**

CHECK ONE BOX: ☐ **MODIFICATION** ☐ **DISCONTINUANCE** ☐ **RECOUPMENT**

INSURER MUST SEND A COPY OF THIS NOTICE TO THE EMPLOYEE AND THE EMPLOYEE'S REPRESENTATIVE

I N S U R E R	1. Insurance Carrier's Name and Address:		2. Self-insured?: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes Please Give Self-insurer Number:	
	3. Name & Address of Insurer's Attorney:		4. Telephone Number of Insurer's Attorney:	
	5. Claim Representative's Name:		6. Claim Representative's Tel. Number & Ext.:	
	7. Insurer's Case File Number:		8. Did Insurer Receive First Report of Injury (Form 101); <input type="checkbox"/> Yes <input type="checkbox"/> No - If Yes - Date Received (mm/dd/yyyy):	
E M P L O Y E E	9. Employee's Name (Last, First, MI):		10. Employee's Social Security Number*:	
	11. Employee's Address (No. and Street, City, State, Zip Code):		12. Date of Birth (mm/dd/yyyy):	
	13. Date of Injury (mm/dd/yyyy):		14. First Day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):	
	15. Name, Address & Telephone Number of Employee's Attorney:			
	Tel. Number -			
G R O U N D S	16. Employer's Name & Address (No. and Street, City, State, Zip Code):			
	17. This is the Insurer's Request to MODIFY Weekly Compensation <input type="checkbox"/> Attach Proper Documents Under 452 CMR 1.07(I)			
	This is the Insurer's Request to DISCONTINUE Weekly Compensation <input type="checkbox"/> Attach Proper Documents Under 452 CMR 1.07(J)			
	This is the Insurer's Request to RECOUP Weekly Compensation <input type="checkbox"/> Attach Proper Documents Under 452 CMR 1.07(K)			
	18. Give Specific Basis for Complaint (continue on reverse side if necessary):			
19. Insurer's Signature :		20. Date Prepared (mm/dd/yyyy):		

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of documents.
 Please Print Clearly or Type. Unreadable forms will be returned.

Form 108 - Revised 11/2001 - Reproduce as needed.

This image shows a full page of blank, lined paper. It features approximately 20 evenly spaced horizontal black lines across its entire width, providing a template for handwriting practice or general note-taking. The margins are consistent on all sides.